

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION****PART I: GENERAL INFORMATION**

Requestor's Name and Address:  DIPTI PATEL, D.C. 6660 AIRLINE DR. HOUSTON, TX. 77076	MFDR Tracking #: M4-09-9419-01
Respondent Name and Box #:  Metropolitan Transit Authority Rep. Box # 19	

**PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Requestor's Position Summary taken from the Table of Disputed Services: "...they are NOT subject to be denied based on any type of medical necessity issue."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - \$227.70
3. CMS 1500s
4. EOBs
5. Pre-authorization letter
6. Medical records

**PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Respondent's Position Summary: "...The carrier's position remains consistent with its EOBs..."

Principle Documentation:

1. Response to DWC 60

**PART IV: SUMMARY OF FINDINGS**

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
8-1-08	97110 97140 97112	151 & W4	1, 2, 4, & 5 1, 2, & 4 1, 2, 4, & 5	\$38.18 \$35.37 \$39.61
8-4-08 8-8-08 8-15-08	97110	151 & W4	1, 3, 4, & 5	\$114.54
<b>Total Due:</b>				\$227.70

## PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled *Medical Fee Guideline for Professional Services* provided on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason codes “151” (payment adjusted because the payer deems the information submitted does not support this many services) and “W4” (no additional reimbursement allowed after review of appeal/reconsideration).
2. A review of the CMS 1500 form for this DOS identifies that the Requestor billed a total of 4 units for code 97110, 2 units of code 97140, and 1 unit of code 97112. A review of the Disputed Table and of the EOBs identify that initial payments had been made for these codes; excluding 1 unit; carrier citing that documentation did not support the number of units billed. A review of the therapy record submitted for this DOS identifies that 4 units of code 97110 was performed, 2 units of code 97140 was performed, and 1 unit of code 97112 was performed; therefore, payment is recommended for one unit of each of these codes in accordance with Rule 134.203 (b) and (c) (1).
  - 97110: \$52.83 divided by 38.087 x \$27.53=\$38.19
  - 97140: \$52.83 divided by 38.087 x \$25.50=\$35.37
  - 97112: \$52.83 divided by 38.087 x \$28.56=\$39.62
3. A review of the CMS 1500 forms for these DOS identify that the Requestor billed a total of 4 units for code 97110. A review of the Disputed Table and of the EOBs identify that initial payments had been made for this code; excluding 1 unit; carrier citing that documentation did not support the number of units billed. A review of the therapy records submitted for these DOS identify that 4 units of code 97110 was performed on each date; therefore, payment is recommended for the additional unit in accordance with Rule 134.203 (b) and (c) (1).
  - 97110: \$52.83 divided by 38.087 x \$27.53=\$38.19 x 3 DOS=\$114.57
4. Per review of Box 32 on the CMS-1500, zip code 77076 is located in Harris County. The maximum reimbursement amount under Rule 134.203 (b) is determined by locality.
5. Per Rule 134.203 (h), ‘reimbursement shall be the least of the (1) MAR amount (2) health care provider’s usual and customary charge; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title.’ The lesser of these three amounts was: the provider’s usual and customary charge.

## PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311  
28 Texas Administrative Code, Rules 134.1, 134.203  
Texas Government Code, Chapter 2001, Subchapter G

## PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$227.70 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

### ORDER:

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

## PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c). Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**